TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAYLOR SURGICAL HOSPITAL

Respondent Name
BITCO GENERAL INSURANCE CORPORATION

MFDR Tracking Number
M4-18-0375-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 12, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All requirements of billing and reconsideration were met by Requestor and reimbursement was still denied."

Amount in Dispute: $11,393.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "carrier's EORs reflect that there are a number of reasons that the provider should not be entitled to reimbursement. We would refer you to both of the EORs."

Response Submitted by: Flahive, Odgen & Latson, Attorneys At Law, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 21, 2017 to March 23, 2017	Outpatient Hospital Services	$11,393.26	$8,548.66

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §133.240 sets out requirements for paying or denying medical bills.
4. 28 Texas Administrative Code §133.250 sets out requirements for reconsideration of medical bills.
5. Texas Labor Code §413.031 entitles health care providers to a division review of services if payment is disputed.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Svc lacks info needed or has billing error(s)
   - 234 – This procedure is not paid separately.
   - 59 – Distinct Procedural Service

- R79 – CCI; Standards of Medical/Surgical Practice
- RN – Not paid under OPPS: services included in APC rate
- RZ0 – Status indicator: Q4 Packaged Lab service
- 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.
- P14 – Payment is included in another svc/procdre occurring on same day
- 231 – MUE procedures cannot be done in same day
- 272 – Coverage/program guidelines were not met
- NNP – Non Network Provider
- R88 – CCI; Mutually Exclusive Procedures
- RT – Right Side
- TC – Technical Component

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the recommended payment for the services in dispute?
3. Is additional payment recommended for the implantable items in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the primary surgical procedure (CPT code 29888) with claim adjustment reason code 272 – "Coverage/program guidelines were not met" and additionally NNP – "Non Network Provider."

   Review of the submitted information finds no valid description or explanation of what "Coverage/program guidelines were not met." If the coverage/program guidelines that were not met were related to the health care provider being a "non network provider," that reason, by itself, is not sufficient to support denial of payment, as non-network providers are eligible for payment for services provided pursuant to the Insurance and Labor Codes and division rules.

   Furthermore, 28 Texas Administrative Code §133.240(f)(15) requires that the paper form of an explanation of benefits shall include the "workers' compensation health care network name (if applicable)." The insurance carrier failed to meet this requirement.

   The explanation of benefits (EOB) does not state that the injured employee is enrolled in a certified HCN. The fields labeled "Network," "Network Branch," and "Sub Network" on the EOBs are *blank*. No name of a certified HCN was found mentioned anywhere on the EOBs.

   Moreover, the EOB does not reference any network policies, rules or contract provisions but rather advises the health care provider that "payment by the *carrier* will be reviewed according to the medical policies and fee guidelines established by the Division."

   The EOB further advises that "pursuant to 133.250 of this title, the health care provider may file an appeal with the insurance carrier if the health care provider disagrees with the insurance carrier's determination"—a rule that would not be applicable if a network were involved, or network procedures were asserted on the EOB.

   28 Texas Administrative Code §133.307(d)(2)(F) states that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   As the respondent has not presented, prior to the filing of the medical fee dispute resolution request, any information to the requestor regarding the injured employee's enrollment in a certified HCN—nor has the carrier presented any valid reasons for denial of payment—the division concludes the respondent has waived the right to raise any such defenses at MFDR. Any newly raised denial reasons or defenses shall not be considered in this review.

   Labor Code §413.031(a)(1) states that a health care provider is entitled to a review of a medical services if that provider is "denied payment or paid a reduced amount for the medical service rendered."

Labor Code §413.031(c) further states that "in resolving disputes over the amount of payment due for services determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment given the relevant statutory provisions and commissioner rules."

For the above reasons, the division has jurisdiction to review the disputed medical fee issues.

Accordingly, the division finds the respondent has not supported the insurance carrier's denial reason(s). The disputed services will therefore be reviewed per applicable division rules and fee guidelines.

2. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying the effective Medicare Outpatient Prospective Payment System (OPPS) formula and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services (CMS) at http://www.cms.gov.

   The provider requested separate payment for implantables. Per Rule §134.403(f)(1)(B), the facility specific amount is therefore multiplied by 130 percent.

   Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) to billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Payment for ancillary items and services is packaged into the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure codes C1713 and C1762 have status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services. These codes were billed under revenue code 278, representing implantable items. Per Rule §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). Accordingly, the facility's total billed charges shall be reduced by the billed amount for any separately paid implantable items (detailed below) when calculating outlier payment(s).
   - Procedure codes 36415, 80053, 85025, and 85610 have status indicator Q4, denoting packaged labs; reimbursement is included in the payment for the primary services.
   - Procedure codes 29881 and 29882 have status indicator J1. Under Medicare payment policies, only the highest-ranking J1 status indicator procedure is paid per claim. Payment for other designated procedures is bundled into payment for the primary service(s). Additionally, per Medicare's NCCI edit payment policy, procedure code 29882 is bundled with procedure code 29888, billed on the same claim. While modifiers (if used appropriately and supported by documentation) may sometimes allow separate payment in the case of NCCI edits; modifiers do not, however, alter the payment status of procedures with respect to J1 status indicators. Separate payment is not allowed.
   - Procedure code 29888 has status indicator J1, denoting packaged services paid at a comprehensive rate. All covered services on the bill are packaged into the primary "J1" procedure (except those with status indicator F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography). This service is assigned APC 5114; it is the highest-ranking J1 procedure on the claim. All other qualifying services are packaged with this procedure — payment for all is included in this comprehensive rate. The OPPS Addendum A rate is $5,221.57. This is multiplied by 60%, for an unadjusted labor-related amount of $3,132.94, which is in turn multiplied by the facility wage index of 0.9618, for an adjusted labor amount of $3,013.26. The non-labor related portion is 40% of the APC rate, or $2,088.63. The sum of the labor and non-labor portions is $5,101.89. These services do not qualify for outlier payment, as the allocated cost of services does not exceed the threshold of 1.75 times the OPPS payment. The Medicare facility specific amount of $5,101.89 is multiplied by 130% for a MAR of $6,632.46.
   - Procedure codes J1100, J1170, J1885, J2270, J2405 and J3010 have status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
   - Procedure code 93005 has status indicator Q1, denoting packaged codes; reimbursement is packaged with payment for any code with status indicator S, T, V or J1. This code is paid separately only if OPPS criteria are met.

3. Additionally, the provider requested separate reimbursement of implantables. Per Rule §134.403(g), implantables — when billed separately by the facility in accordance with subsection (f)(1)(B) — shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

   Review of the submitted documentation finds the following implantables:

   - "Rigidifix pin" as identified in the operative report, and labeled on the invoice as "RIGIDIFIX FEM 3.3MM S/T XPIN" with a cost per unit of $510.00 at 2 units, for a total cost of $1,020.00;
   - "Bio-Intrafix Sheath" as identified in the operative report, and labeled on the invoice as "BIOINTRAFIX TBIAL SH LRG 30MM" with a cost per unit of $372.00;
   - "Bio-Intrafix Screw 8 to 10 mm" as identified in the operative report, and labeled on the invoice as "BIOINTRAFIX 8-10MMX30MM TPRSCR," with a cost per unit of $350.00.

   Per Rule §134.403(b)(2), "implantable" means an object or device that is surgically: (a) implanted, (b) embedded, (c) inserted, (d) or otherwise applied, and (e) related equipment necessary to operate, program and recharge it.

   The requestor's itemized statement indicates two additional implantable items: "SYSTEM REPAIR MENISCAL 1" and "TENDON TIBIALIS POSTERIO." However, insufficient information was presented to support that these items meet the definition of implantable in Rule §134.403(b)(2). Moreover, the Operative Report failed to document such items were implanted.

   The provider further presented invoices for two reamers, an "ACL ACC DISPOSABLES KIT," and a "MISCELLANEOUS KIT." However, review of the submitted records finds insufficient documentation to describe and identify such items or support they meet the definition of implantables under Rule §134.403(b)(2). Nor did the Operative Report document that such items were implanted. Accordingly, the submitted information does not support additional reimbursement for these items.

   The division thus finds the total net invoice amount (exclusive of rebates and discounts) is $1,742.00. The total add-on amount (of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission) is $174.20. The total recommended reimbursement amount for implantable items is $1,916.20.

4. The total recommended reimbursement for the disputed services (including implantable items) is $8,548.66. The insurance carrier has paid $0.00, leaving an amount due to the requestor of $8,548.66.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds the requestor has established that additional reimbursement is due. As a result, the amount ordered is $8,548.66.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $8,548.66, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	December 8, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (form DWC045M) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.